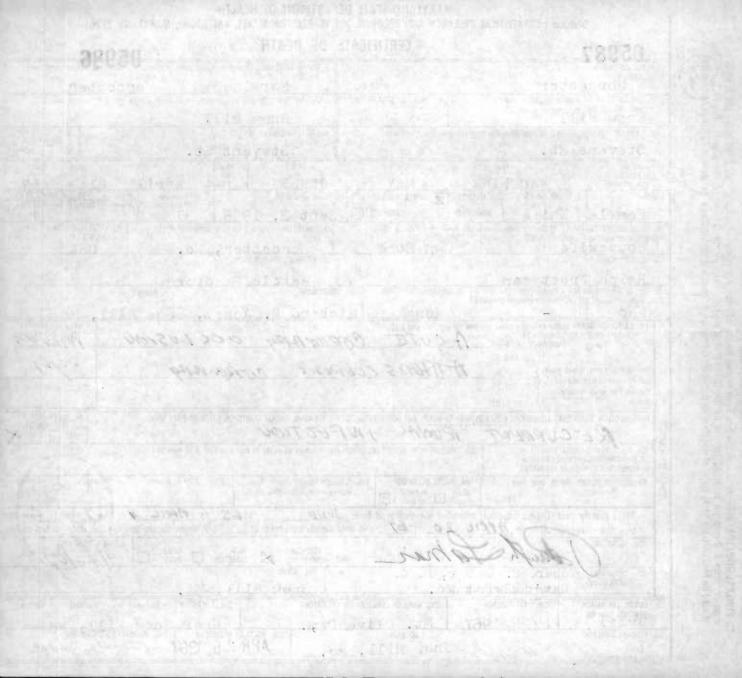
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Dorcest MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH CF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) hours filled d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE d. STREET ADDRESS ON A FARM? 3 within NO S YES etely carbon 3. NAME OF DECEASED First Middle DATE Month Day be executed with Last event, (Type or print) compr DEATH 19 AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED 8. remove. NEVER MARRIED any and WIDOWED X DIVORCED (yrs. physician an please reval, and in .⊆ 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY stic. death certificate 13. FATHER'S NAME removal, 14. MOTHER'S MAIDEN NAME NIE s the burial-transit permit, ior to burial, cremation, or r 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMAN Address 17. BOX167A (Yes, no, or unkown) (If yes give war or dates of service) in Kla INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO law requires Cenditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the prior underlying cause last. has 98 (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOWEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY certificate h hed for use it. of Health I nse PERFORMED? NO A YES [PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING T 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) etached f Dept. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) det factory, street, office bldg., etc.) Hour a.m. After While Not While OR ATTENDING be retained by 19 at work at work p.m. DIRECTOR: A age 3 should lied with the 3 P 21. I certify that (I) (this hospital) attended the deceased from that (I) (we) last and that death occurred attack M. from the causes and on the date stated above. saw the deceased alive on 22a. SHONATURE 22b. DATE SIGNED page MED. DIRECTOR ATTENDING PHYS. STAFF PHYS. Page 4 may PHYSICIATUS NAME CAPPEL 22c. 22d. ADDRESS director, p 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 2 12UriA OF 24. FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR AIS 20M 1/65

32030 a certa myscareleles Charme George and its Hostmake tel 63-14 CHERORD & Schotte ma Berlin, Md and the state of t

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

2/2	05983	7		CERTIFICAT	E OF	DEATH			nanoc			
inerol (Mercol	1. PLACE OF DEATH 0. COUNTY. WOrc	ester		MARYLAND	2. US	STATE Mary	Where deceose	b. COU	non: Kesidence befo NTY Or ceste:			
by the fune Pages ar	U, CIII OK IOWIN I	If outside corporate limit give nearest town)	,	c. LENGTH OF STAY IN 1b	c. CIT	T UK TUWN (IT O	utside corporot		RAL ond give neore			
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Stevens St.					d. STREET ADDRESS Stevens St.				e. IS RESIDENCE ON A FARM? YES NO X		
	3. NAME OF DECEASED (Type or print)	MADEL	st TME	Middle MAY	TO	lost NES	4. DATE OF DEATH	Mon Apri		y Year 19 6 7		
ev ev	s. sex Female	6. COLOR OR RACE	7. MARRIEO [WIDOWED [8. DATE	OF BIRTH	9.	AGE (In years lost birthdoy)	IF UNDER 1 YEAR Months Doys	IF UNDER 24 HRS.		
by the ottending physician ond completely filled in ronsit permit. Then please remove carbon papers. cremotion, or removal, and in any event perithin 72 h	10o. USUAL OCCUPATION	(Give kind of work done	10b. KINI	D OF BUSINESS OR USTRY	11. 8	t 2, 1	& Stote, or for		12. CITIZEN C	?		
	during most of working life, even if refired) Housewife Own Home Worcester, Md. USA 14. MOTHER'S MAIDEN NAME									Α		
inding l	Ralph Prettymen 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address											
s been signed os the burial-t rrior to buriol,	18. CAUSE OF DI PART I. DEA	EATH (Enter only one cou TH WAS CAUSED BY:	se per line for (o), (b), ond (c).)	40,54	rd R.		LVS10	IN	Md ITERVAL BETWEEN INSET AND DEATH		
	4/20/ Conditions, if ony		TO	THORS CLE			Reni	ring		5 gg		
	rise to immediat stating the unde last.		. /									
	PART II. OTHER SI	GNIFICANT CONDITIONS C		DEATH BUT NOT RELATED TO		AINAL DISEASE COI	NDITION GIVEN	IN PART 1(o)		PERFORMED? YES NO		
ertificot led for 1. of He	(IF FITHER NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	RIBE HOW INJURY OCCURRED	. (Enter no	oture of injury in	Port I or Port	II of item 18.)				
detocharte Dep	20c. TIME OF INJU-	10	20d. INJ While at work			JURY (Home, forn et, office bldg., etc.		(City or town)	(County)	(Stote)		
R: Afte ould be the Store	21. I certi	fy that (I) (this has eceased alive on _/	pital) attende	ed the deceased fram_ 0_1967_, and th	JUNE at death	n accurred at	19 <u>63</u> , to	fram causes	21, 19 <u>67,</u> 1 and an the do	hat (!) (we) las ite stated abave		
orrectors of the second of the		220. SIGNATURE ATTENDING MED. STAFF 22b. DATE SIGNED, PHYS. DIRECTOR PHYS. DATE SIGNED, 4/22/67										
or, pag d be fill	22c. PHYSICIAN'S NAME (Type	NavniskxR		id.		Snow H		Md		/		
direct shoul	230. BURIAL, CREMATIC BURIAL (Specify	11/214	1967	23c. NAME OF CEMETERY OF		1.	Ne	ar Snot	w Hill	ty) (Stote)		
VR A15 (4) 20 M 1/66	24. FUNERAL DIRECTO	10 Sau	us	now Hill,	Md.	DATE AP	R 26		EĞISTRAR'S SIGNATI	Judge.		



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 05988 HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY orcester ny delay is 2, and 3 ta PM3. Page a. COUNTY a. STATE Worcester MARYLAND Mary land b. CITY OR TOWN (If autside carparate limits, LENGTH OF STAY IN 15 regular Nite c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Departme write RURAL and give nearest tawn) after WHALEYVILLE Rural shift employee Showell 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Office along with farm and 2 with the State De evoat within 72 haurs in Item 18. Give Pages 1, R # 1 B & S Hatchery Box 177-C YES NO X 24 haurs after death. Middle First Last 4. DATE Month Day Year DECEASED April 22 1967 William. Mac Fee Long (Type ar print) DEATH S. SEX 6. COLOR OR RACE 7. MARRIEDXIX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED B. DATE OF BIRTH lost birthday) Days Hours White Male. WIDOWED July 12, 1912 DIVORCED 10a. USUAL OCCUPATION (Give kind af wark dane during mast af warking life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRYS Worcester County pages I ward "pending" in pencil in the Chief Medical Examiner's Hatchery employee
13. FATHER'S NAME Chick Hatehery pencil 14. MOTHER'S MAIDEN NAME This certificate shauld be executed within Vernon M. Long Margaret Baker pup 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address used as a burial-transit permit. burial, crematian, ar remaval, (Yes, na, arunknawn) (If yes give war or dates of service 213-18-5196 Mrs. Rada Long, Whaleyville, Maryland INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: ONSEL AND DEATH ACUTE CORONARY OCCLUSION IMMEDIATE CAUSE (a) the certificate, writing the ward 4 shauld be farwarded to the Ch DUE TO Coronary atheroscloeosis unknown Conditions, if ony, which gave rise ta immediate cause (a), DUE TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? please execute the certificate, NO designated agent, priar to 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 3 shauld PRIMARY Or CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Haur a.m. Not While factory, street, office bldg., etc.) may be retained far your FUNERAL DIRECTOR: Page at wark at work 21. I certify that I taok charge of the remains described above, held an Autapsy Inspection xx. Inquiry &x and in my apinian Matural causes XX death resulted fram: Accident . Suicide . Hamicide 🗍 Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIG NATURE O DEPUTY DEPUTY MEDICAL EXAMINER EXAMINER'S Health o NAME (Type) ROBERT C. LA MAR, M.D. 104 Bay St States (first dry, town, or county) 4-24-67 23c. NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Tawn) 0 Bur (pecify) 4/25/67 Lewis Cemetery Whaleysville, Worces. Md. 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 2Sb. atson Selbyville, Dela. DATEAPR 27 196 VR A15ME (5) 6M 1/66

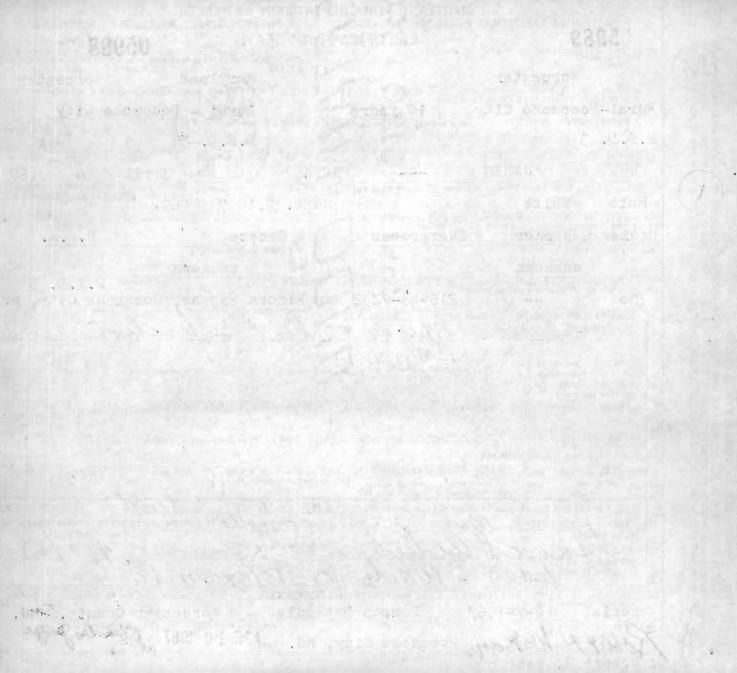
MARYLAND STATE DEPARTMENT OF HEALTH

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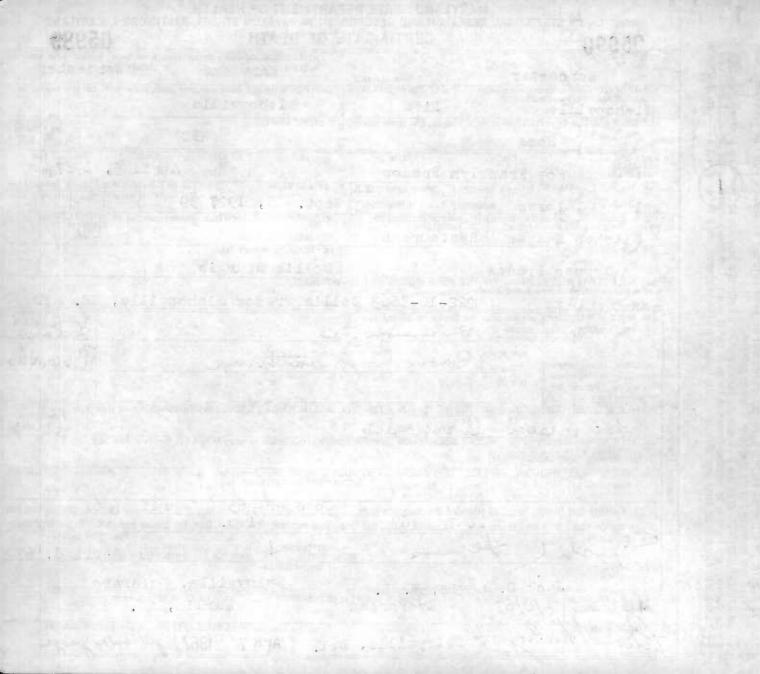
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05989 CERTIFICATE OF DEATH death. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) b. COUNTY after Worcester Maryland MARYI AND Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours Rural-Pocomoke City 10 years Rural - Pocomoke City Ξ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET AODRESS e. IS RESIDENCE 24 ON A FARM? R.F.D. R.F.D. YES X NO within ely NAME DE First 4. DATE Middle Lest Month Day Year DECEASED JAMES PAPPAS (Type or print) 19 67 April DEATH executed 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 00 7. MARRIED X NEVER MARRIED last birthday) Months I Davs Hours White Male Sept. WIDOWED DIVORCED . 1897 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician certificate be INDUSTRY COUNTRY? Dealer & Broker Evergreens U.S.A. Greece 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova attending parmit. Then unknown unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? transit permit. 16. SOCIAL SECURITY NO. 17. INFORMANT Address death (Yes, no, or unkown) (If yes give war or dates of service) 216-48-7232 No Mrs Elnora Pappas Pocomoke the 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), end (c). INTERVAL BETWEEN that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) burial-burial, DUE TO Conditions, If eny, which gave rise to immediate the r to DUE TO cause (a), stating the as th underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health p PERFORMED? certificate the hospital or NO T YES PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING [DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) hed t. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While p.m. at work at work o 21. I certify that (I) (this hospital) attended the deceased from All DIRECTOR: age 3 should lied with the . that (I) (we) last and that death occurred at // PM, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DAPE SIGNED OR page 4 may M.D. DIRECTOR PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) NAME OF CEMETERY OR XELEMANDICX BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county) (State) 2 REMOVAL (Specify) Burial 4-7-1967 Remson Methodist Worcester County Md 25a. REC'D BY REGISTRAR 25b. BEOISTRAR'S S SUNERAL DIRECTOR Pocomoke City. Md. VR A.15 (4) 20M 1/65 Watson



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 0599 USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) PLACE DF DEATH a. COUNTY Maryland b. COUNTY Wordester Worcester after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours Bishopville Bishopville Life Ξ on papers. within 72 h d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? RFD Home NO YES PE ately NAME OF Middle Year 3. First Last 4. DATE Month Day remove carbo remove carbo n any event, w DECFASED DF DEATH April Predow Rov Franklyn (Type or print) executed AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED last birthday) Months | NEVER MARRIED Davs 18, Sept. WIDOWED DIVORCED Colored Male 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT physician and please re = 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) lease and in pe COUNTRY? INDUSTRY Maryland Kitchen Helper Restaurant death certificate removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Dollie Sturgis Cyrues Predow 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address been signed by the atten the burial-transit permit. or to burial, cremation, or (Yes, no, or unkown) (If yes give war or dates of service) Dollie Predow Bishopville, Md. RFD 222-10-6663 the INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) days DUE TO Conditions, if any, which gave rise to immediate DUE TO (a), stating the has be as the underlying cause last, (c) CERTIFICATION 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) r this certificate h detached for use te Dept. of Health of for use i Health p PERFORMED? NO X YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) TO HOSPITAL OR ATTENDING PHY
Page 4 may be retained by the
TO FUNERAL DIRECTOR. After thi
director, page 3 should be det.
should be filed with the State D Hour a.m. While Not While at work at work p.m. 19 67 that (1) (we) last 1905 April Uctober 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 1 p.M. from the causes and on the date stated above. saw the deceased alive on Apr 67 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. ATTENDING. April M.D. PHYS. DIRECTOR 220 PHYSICIAN'S 22d. ADDRESS NAME (Type) Selbyville. Delaware Jack LAW! 23c NAME OF CEMETERY OR CREMATORY rin, (city, town or county) (State) 23a. BURIAL CREMATION, REMOVAL (Specify) PATE THEREOF 25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR ADDRESS Selbyville, Del. 196 VR A15 (4) 15M 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 05991 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY P.M3. Page MARYLAND CLENGTH OF STAY IN 16 b. CITY OR TOWN (II TOWN (If outside corparate limits write RURAL and give nearest town after Office along with form hours Give Pages 1, ERIN ote Middle 3. NAME OF 4. DATE DECEASED emAN (Type or print) DEATH IF UNDER 1 YEAR 6. COLOR OR RACE AGE Months Hours in Item 18. hours WIDOWED 10o. USUAL OCCUPATION (Give kind of work done BIRTHPLACE (Stote or foreign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) e INDUSTRY WINDSOR, VIRGINIZ 24 any pencil within oleMAN ond 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT permit. e certiticote, writing the word "pending" i should be forwarded to the Chief Medical (Yes, no, or ponknown) (If yes give war or dotes of service remayal, CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c).) buriol-transit PART I. DEATH WAS CAUSED BY: OCCIUSION 10 IMMEDIATE CAUSE (0) should writing the word cremation, DUE TO ASCUD Conditions, if ony, which gave rise to immediate couse (o), DUE TO certificate stoting the underlying couse 0 SD lost. used 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) please execute the certificate. 0 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 should ogent, prior PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. AL EXAMINER: 20c. TIME OF INJURY Manth. Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Poge ot work ot work designoted 21. I certify that I took charge of the remoins described obove, held on Autopsy Inspection ond in my opinion the funeral directar. death resulted fram: Natural causes Suicide Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER TO DEPUTY DEPUTY MEDICAL 0 **EXAMINER'S** Health NAME (Type) 23o. BURIAL, CREMATION, (County) 0 misMethod NEWARK 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5) 6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05992 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY b. COUNTY pletely filled in by the fune carban papers. Pages 1 o ent, within 72 hours after d MARYLAND Worcester Maryland Worcester b. CITY OR TDWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Snow Hill Snow Hill d. NAME DF HDSPITAL DR INSTITUTION (If not in haspital, give street address) IS RESIDENCE d. STREET ADDRESS DN A FARM? 111 W. Federal YES ND Middle DATE 3. NAME OF Year tarban DECEASED OF 19 67 Benjamin April (Type ar print) Truitt DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. CDLDR DR RACE 8. DATE DF BIRTH NEVER MARRIED remave last birthday) Manths Days Haurs WIDDWED DIVORCED 1898 Male Jan. 9. 69 White pup KIND DF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? 10o. USUAL DCCUPATION (Give kind of work done 10b 11. BIRTHPLACE (County & State, or fareign country) physician a during most af warking life, even if retired) INDUSTRY Fertilizer Snow Hill. Maryland General Manager TISA 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Benjamin T. Sally Mary Fooks signed by the attending 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) Snow Hill. Yes 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: MICHEXIA & INANITION IMMEDIATE CAUSE (a) DUF TO ADENO CARGNOMA OR PROSTATE Conditions, if ony, which gove rise to immediate cause (o). DUE TO WITH METASTISES stating the underlying cause as the TO FUNERAL DIRECTOR: After this certificate has been Health prior ta last. 19. WAS AUTOPSY PERFORMED? PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) the haspital ar 20b. DESCRIBE HDW INJURY DCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20c. TIME DE INILIRY Month. Day. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Nat While at wark ot work 1963, to RPRIL 27, 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased fram JUNE be retained saw the deceased alive an APRIL 27 1967, and that death accurred at 4:15MM, fram causes and an the date stated abave. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR PHYS M.D. 22d. ADDRESS PHYNCIAN'S NAME (Type) Robert C. LaMar, M. D. Bay Street, Snow Hill, Maryland 104 director, shauld 23c. NAME OF CEMETERY DR CREMATDRY 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, Burial (Specify) 11/30/67 Episcopal Snow Hill 25b. REGISTRAR'S SIGNATURE ADDRESS 2So., REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Charles 1967 DAT Snow Hill Maryland

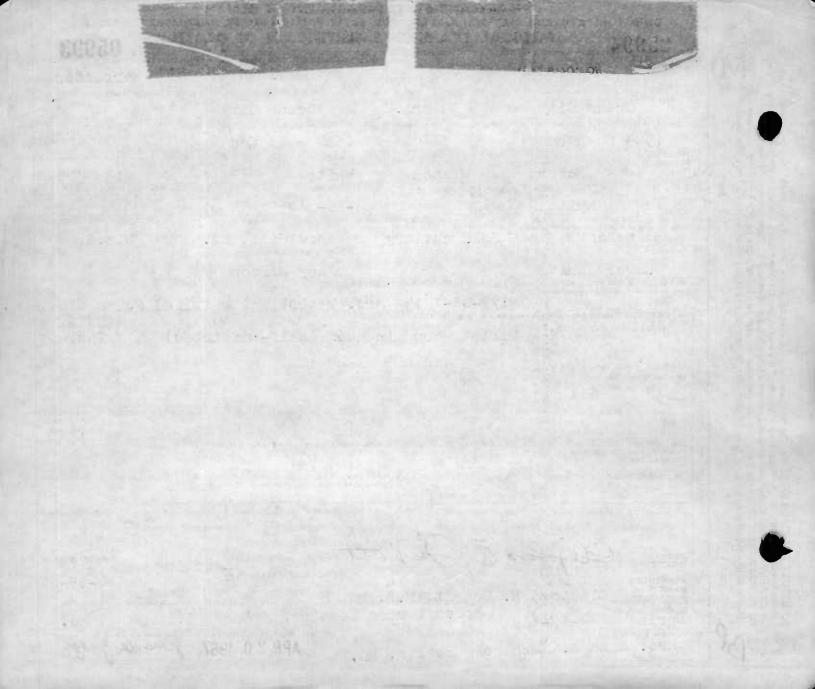
MAKTLAND STATE DEPARTMENT OF HEALTH

BUREAU SECTION OF THE PROPERTY THE VORBLE HERV RS MALE STATE OF THE The state of the s CHILDEND A INANITION 371/61 BOEKE CAROLLING OR PRESTATE 141TH 10 ETASTISES 1860 27 67 10 NE 9150 APRIL 27 67 the then x and 4/28/6 PORT TO THE RESERVE OF THE PROPERTY OF THE PRO YAM I YAMI I YAM I YAM I YAM I YAM I YAM I YAM I YAMI I YAMA I YAMA I YAMI I YAM I YAMA I YA

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 N5992 MEDICAL EXAMINER'S FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) delay . o. COUNTY o. STATE b. COUNTY Page MARYLAND b. CITY OR TOWN (If autside corporate limits (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 c. CITY OR TOWAL gud PM3 write RURAL and give narest town) d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITAL OR (NSTITUTION (1) not in hospital, give street address) ON A FARM? farm NO X in Item 18. Give Pages be executed within 24 haurs after death with 3. NAME OF Middle Year First DECEASED DEATH Type or print) Office alang IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED rthdoy) Months Hours 72 haurs after death WIDOWED DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR INDUSTRY COUNTRY ?. pending" in pencil in ef Medical Examiner's 13. FATHER'S NAME 14. MOTHER'S MAIDEN WAS DECEASED EVER 16. SOCIAL SECURITY NO INFORMAN' (Yes no far unknown) (If yes give war or dotes of service within CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c) PART I. DEATH WAS CAUSED BY burial-transit any event IMMEDIATE CAUSE (a) This certificate shauld please execute the certificate, writing the ward DUE TO Conditions, if ony, which gave (b) rise to immediate couse (o), farwarded ta .= DUE TO stoting the underlying couse 0 ond SD lost. used WAS AUTOPSY PERFORMED? remayal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO pe 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 1) of item 1B.) 3 shauld PRIMARY Or CONTRIBUTING crematian, ar CAL EXAMINER: CAUSE OF DEATH. 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. yaur Not While FUNERAL DIRECTOR: Page at work ot work 21. I certify that I taok charge of the remains described obove, held on Autopsy Inspection and in my apinian death resulted fram: Natural causes Suicide Hamicide Undetermined manner may be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER Health prior SIGNATURE TO DEPUTY necessary, DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) BURIAL, CREMATION or Town) 0 REMOVAL (Specify) 2So. REC'D REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15ME (5) DATE AT

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FOR STATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLA 05994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	D3									
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0 g 4 0 H	Burial 4-17-167 1103 by defeat Cemetery Snow Hill	Md.									
VR A15ME	Mrs. Anna A. Burbage Berlin. Md. 248. REC'D BY REGISTRAR'S SIGNATURE 248. REC'D BY REGISTRAR'S SIGNATURE	del.									
5M 1/62	Mrs. Anna A. Burbage Berlin, Md. DATAPR 20 1967 guartes guar	0									



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05995 requires that the death certificate be executed within 24 haurs after death the funeral ages then a 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY Worcester o. COUNTY Maryland Worcester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town) 4 Yrs. Pocomoke Pocomoke bon papers. within 72 ho e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES IX NO BethEden Ch. Rd. BethEden Ch. Rd., 3. NAME OF Middle DATE Month Dov Year remove carbon DECEASED 1967 THOMAS ROWE WIDDOWSON 10 DEATH (Type or print) IF UNDER 1 YEAR | IF UNDER 24 HRS. B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours DIVORCED WIDOWED 10-6-1903 Male White 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? U.S.A Salesman, Ret. Retail Sales Maryland, Somerset 14. MOTHER'S MAIDEN NAME cremation, ar removal Mary Ellen Rowe Frank Widdowson the attending p 1S. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT 16. SOCIAL SECURITY NO. Mrs. T.R. Widdowson See Sec.#2 ONSET AND DEATH 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: signed by the burial-transit IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), Disease DUE TO stoting the underlying couse as the Page 4 may be retained by the hospital or attending IO FUNERAL DIRECTOR: After this certificate has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? for use CERTIFICATION YES NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While of work OR ATTENDING at work 19_1/2 /that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 19 64 ta ah. 10 1967, and that death accurred at M, fram causes and an the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22n SIGNATURE ATTENDING DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, I should be 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 230. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)
Burial Hebron, Wicomico Maryland Springhill Memory Garden 25b. REGISTRAR'S SIGNATI 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Salisbury, Maryland VR A15 (4) 20 M 1/66 Hill Funeral Home

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. PLACE OF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY: DREE hours after filled in by the ACUST MARYLAND OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest town) 72 hours ISR 4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE DN A FARM? d. STREET ADDRESS within YES N NO L retely executed within 3. NAME OF DECEASED First Middle DATE Month Oav Last 4. (Type or print) DEATH 19 6 lease remove can 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS | last birthday) | Months | Days | Hours | Min. 7. MARRIED 8. NEVER MARRIED and 8 WIDDWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS DR 12. CITIZEN OF WHAT (County & State, or foreign country) physician certificate be during most of working life, even if retired) COUNTRY? GTI TO RE 0 removal. 13. FATHER'S NAME MDTHER'S MAIDEN NAME attending permit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 17. INFORMANT FUNERAL DIRECTOR: After this certificate has been signed by the atten lirector, page 3 should be detached for use as the burial-transit permit. hould be filed with the State Dept. of Health prior to burial, cremation, or D HOSPITAL OR TITENDING PHYSICIAN: The law requires that the death Page 4 may be retained by the hospital or attending physician. (If yeggive war or dates of service) (Yes, no, or unkown) 0 ONSET AND OEATH CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) CERTIFICATION WAS AUTDPSY PART II, DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO X 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of Item 18.) MEDICAL 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from 1900 L saw the deceased alive and that death occurred at M, from the causes and on the date stated above. 224. SIGNATURE 22b. DAVE SIGNED ATTENDING MED. PHYS. DIRECTOR M.D. PHYS. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, p should be 1 ROBERT (State) BURIAL, CREMATION. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. REMOVAL (Specify) 2 0 RIAL FUNERAL DIRECTOR **ADORESS** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64

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